



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

September 15, 2006

FILE COPY

Mary Paul, Administrator
Paramount Parks at Eagle
815 Eagle Road
Eagle, ID 83616

License #: RC-838

Dear Ms. Paul:

On August 9, 2006, a survey was conducted at Paramount Parks Health Care at Eagle Llc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

This office is accepting your submitted plan of correction.

Should you have questions, please contact Patrick Hendrickson, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

PATRICK HENDRICKSON, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

PH/slc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



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August 23, 2006

CERTIFIED MAIL #: 7003 0500 0003 1966 8831

Mary Paul, Administrator
Paramount Parks at Eagle
815 Eagle Road
Eagle, ID 83616

FILE COPY

Dear Ms. Paul:

Based on the complaint investigation survey conducted by our staff at Paramount Parks Health Care at Eagle LLC on **August 9, 2006**, we have determined that the facility failed to protect residents from inadequate care based on the failure to provide services of assistance and monitoring of medications for one of one sampled resident reviewed for medication assistance.

This core issue deficiency substantially limits the capacity of Paramount Parks Health Care at Eagle LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **September 25, 2006**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ♦ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ♦ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ♦ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ♦ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ♦ What date will the corrective action(s) be completed by?

Mary Paul, Administrator
August 23, 2006
Page 2 of 2

Return the **signed** and **dated** Plan of Correction to us by **September 5, 2006**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**September 5, 2006**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **September 5, 2006**, your request will not be granted.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Paramount Parks Health Care at Eagle LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/sm

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Marilyn Kelseth, R.N., Long Term Care Unit, Region IV Medicaid Services - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R838	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/09/2006
NAME OF PROVIDER OR SUPPLIER PARAMOUNT PARKS AT EAGLE		STREET ADDRESS, CITY, STATE, ZIP CODE 815 EAGLE ROAD EAGLE, ID 83616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiencies were cited during the complaint investigation conducted at your residential care/assisted living facility on August 9, 2006. The surveyors conducting your survey were: Patrick Hendrickson, RN Team Leader Health Facility Surveyor Debbie Sholley, LSW Health Facility Surveyor Survey Definitions: MAR = Medication Administration Record mg = milligrams Q = every UAI = Uniform Assessment Instrument	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on interview, record review, and review of a complaint from the public, it was determined the facility failed to provide services of assistance and monitoring of medications for 1 of 1 sampled resident (#1) reviewed for medication assistance. The findings include: Review of a complaint from the public on 8/9/06, revealed the complainant alleged Resident #1 did	R 008		

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

5HXJ11

If continuation sheet 1 of 3

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R838	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/09/2006
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R 008	<p>Continued From page 1</p> <p>not receive his eye drops as prescribed by his physician.</p> <p>Review of Resident #1's record on 8/9/06 revealed the resident was admitted on 12/28/05 with diagnoses which included macular degeneration, coronary artery disease, hypertension, atrial fibrillation, and diabetes.</p> <p>Further review of the record revealed an NSA dated 1/10/06 that documented the facility would assist with all medications as ordered by the medical doctor.</p> <p>Review of Resident #1's physician's orders on 8/9/06 revealed:</p> <p>On 4/7/06 the physician had written an order for Vigamox, 1 drop, 4 times a day, in the right eye.</p> <p>On 4/10/06 the physician changed the order to Vigamox, 1 drop, 2 times a day, 12 hours apart, in the right eye.</p> <p>On 4/18/06 the physician again ordered Vigamox, 1 drop, 2 times a day, 12 hours apart, in the right eye.</p> <p>(Vigamox is used to treat Inclusion Conjunctivitis and/or Corneal ulcers. This information is provided by the Nursing 2006 Drug Handbook).</p> <p>Review of Resident #1's MAR for April 2006 documented the resident was assisted with Vigamox, 4 times a day, in the right eye, from 4/7/06 thru 4/18/06.</p> <p>On 8/9/06 at 11:30 a.m., the administrator who was also the facility's nurse confirmed the resident had received the wrong dose of Vigamox</p>	R 008		

Bureau of Facility Standards

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R 008	Continued From page 2 from 4/10/06 through 4/18/06. She stated she did not know why the Vigamox was given 4 times a day during that time instead of 2 times a day as ordered. The Resident did not receive his Vigamox from 4/10/06 through 4/18/06 as prescribed by his physician. The facility did not assist the resident with his medications as documented in his NSA. This failure resulted in inadequate care.	R 008		



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August 23, 2006

Mary Paul, Administrator
Paramount Parks at Eagle
815 Eagle Road
Eagle, ID 83616

Dear Ms. Paul:

On August 9, 2006, a complaint investigation survey was conducted at Paramount Parks Health Care at Eagle LLC. The survey was conducted by Patrick Hendrickson, R.N., and Debra Sholley, L.S.W. This report outlines the findings of our investigation.

Complaint # ID00001558

Allegation #1: The facility was not following physician orders. An identified resident had eye surgery on April 4, 2006. On April 18, 2006, the resident's physician realized that the facility was not assisting the resident correctly with his eye drops.

Findings: Based on interview, record review, and review of a complaint from the public, it was determined that the facility did not assist the identified resident with his eye drops as prescribed by the physician.

Review of a complaint from the public on August 9, 2006, revealed that the complainant alleged that an identified resident did not receive his eye drops as prescribed by his physician.

Review of the identified resident's record on August 9, 2006 revealed that the resident was admitted to the facility on December 28, 2005 with diagnoses which included macular degeneration, coronary artery disease, hypertension, atrial fibrillation, and diabetes.

Further review of the record revealed a negotiated service agreement (NSA) dated January 10, 2006 that documented the facility would assist with all medications as ordered by the medical doctor.

Review of the identified resident's physician's orders on August 9, 2006 revealed:

- On April 7, 2006, the physician had written an order for Vigamox, one drop, four times a day, in the right eye.
- On April 10, 2006, the physician changed the order to Vigamox, one drop, two times a day, 12 hours apart, in the right eye.
- On April 18, 2006, the physician again ordered Vigamox, one drop, two times a day, 12 hours apart, in the right eye.

(Vigamox is used to treat Inclusion Conjunctivitis and/or Corneal ulcers. This information is provided by the Nursing 2006 Drug Handbook).

Review of identified resident's medication assistance record (MAR) for April 2006 revealed documentation that the resident was assisted with Vigamox, four times a day in the right eye, from April 7, 2006 through April 18, 2006.

On August 9, 2006 at 11:30 a.m., the administrator, who was also the facility's nurse, confirmed that the resident had received the wrong dose of Vigamox from April 10 through April 18, 2006. She stated that she did not know why the Vigamox was given four times a day during that time instead of two times a day as ordered.

The Resident did not receive his Vigamox from April 10, 2006 through April 18, 2006 as prescribed by his physician.

- Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for inadequate care. The facility is required to submit a plan of correction.
- Allegation #2: The air conditioner in the identified resident's room has not been working properly for the past month. It is either too hot or too cold. The facility has not fixed the problem, and has refused to move the identified resident to another room until the problem is resolved.
- Findings: Based on interview and review of maintenance records, it was determined that the air conditioner was not working properly.

Review of the facility's "Maintenance Log" on August 9, 2006 revealed that the facility was first made aware of the air conditioner problem on May 23, 2006, at which time they notified a refrigeration company to fix the air conditioner.

Further review of the "Maintenance Log" revealed two invoices from a refrigeration company dated May 23, 2006 and June 7, 2006 for repairs to the air conditioner in the identified resident's room.

On August 9, 2006 at 10:30 a.m., the maintenance supervisor stated there was some problems with the air conditioner in the identified resident's room. He stated he switched out the resident's air conditioner with another air conditioner and still had problems. He said he went through three different transistors on the motherboard, and finally determined that the problem was a manufacturing defect and the air conditioner was replaced. He further stated that the facility offered to move the identified resident to another room until the air conditioner was fixed.

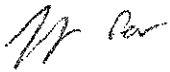
On August 9, 2006 at 11:00 a.m., the identified resident stated, "I guess they did their best to fix it." He further stated that the facility offered to move him to another room until the air conditioner was fixed. He stated the air conditioner was currently working fine.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by attempting to repair or replace the air conditioner, and offering the resident the option of moving to different room until the air conditioner was fixed.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



PATRICK HENDRICKSON, R.N.
Team Leader
Health Facility Surveyor
Residential Community Care Program

PH/sm

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program